Benson Dermatology & Skin Cancer
contact@bensonderm.com
(PLEASE PRINT CLEARLY)

Full Name______________________________ Home Phone (____) ______________

Address______________________________ Work Phone (____) ______________

City______________ State ______ Zip______ Cell Phone (____) ______________

Social Security #________-________-________ Email ______________@________

Date of Birth______________________________ Preferred method of contact (circle one):

Marital Status: Single Married Divorced Widowed HOME WORK CELL

Gender: Male Female

EMERGENCY CONTACT
(Person to contact in case of an emergency)

Full Name______________________________ Relationship to Patient ______________

Home Number (_____) ______________________ Other Number (____) ______________

PATIENT INFORMATION

Occupation/School: ______________________ **Over the age of 65:** Do you have an Advance Directives (Living Will)? YES NO

Circle one: Race: White Black Asian Hispanic Other: ________

Ethnicity: Hispanic Not Hispanic

Primary Language: English Spanish Other: ________

INSURANCE

Primary Insurance

Subscriber's Full Name ____

Address ______________________City ____________ State________ Zip ________

Employer /School ____

Date of Birth ________ Phone Number (____) ____________Relationship to Patient ____________ Gender: M/ F

Insurance Company ______________Group #____________ Policy #______________

Address ______________________ City ____________ State________ Zip ________

Secondary Insurance

Subscriber's Full Name ____

Address ______________________City ____________ State________ Zip ________

Employer /School ____

Date of Birth ________ Phone Number (____) ____________Relationship to Patient ____________ Gender: M/F

Insurance Company ______________Group #____________ Policy #______________

Address ______________________ City ____________ State________ Zip ________

RESPONSIBLE PARTY
(REQUIRED IF PATIENT IS UNDER THE AGE OF 18)

Full Name____

Address______________________City____________ State ________ Zip________

Employer/School ____________ Date of Birth________ Phone # (____) ________ Relationship to Patient________

Benson Dermatology & Skin Cancer

Patient Name: ____

Height: ____________________________ **Weight:** ____________________

Preferred Pharmacy: ____

Type of Visit: ____ New ____ Follow-up

Referred By: ____

Past/Present Medical History:

___Anemia
___Arthritis
___Asthma
___Autoimmune disorder
___Bladder infections
___Bleeding tendency
___Cancer (skin/other)
___Chickenpox
___Dementia
___Diabetes
___Epilepsy/seizures
___Heart disease
___Hepatitis
___High blood pressure
___High cholesterol
___HIV
___Kidney disease
___Measles
___Melanoma
___Migraine headaches
___Mitral valve prolapse
___Mumps
___Pace maker/defibrillator
___Pregnant
___Rash
___Rheumatic fever
___Scarlet fever
___Shingles
___Stroke
___Thyroid disease
___Tuberculosis
___Venereal disease
___Whooping cough

Other: ____

Surgeries: ____

____

Present Medications: ____

____

____

Allergies: ____

Vaccines: Influenza Y/N (Date):____________ **Pneumococcal** Y/N (Date):___________

Social History: ____ Smoking ____ Alcohol ____Drug abuse

Family History: ____Skin cancer ____Melanoma ____Rash ____Diabetes

Other:

____

____

Benson Dermatology & Skin Cancer

============FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT=========

I authorize treatment by Benson Dermatology of the person ____________________________ and agree to pay all charges including copayments for such treatment upon check out of each visit.

I agree that this office will prepare and file any claims which I have in connection with treatment received, and I agree, as evidence by my signature, to assign payment of any applicable benefits payable by my insurance company to this office. I also authorize the release of all information necessary to secure payment of my claim and the downloading of any medical history by Benson Dermatology. A copy of this authorization will be considered as valid as an original.

I understand Benson Dermatology is not responsible for collecting payment from my insurance company. If the company delays or withholds payment of my claim, I will be responsible for direct payment. I am also responsible for any or all amounts which insurance does not pay, including deductibles, co-insurance, or charges not covered. I understand any unpaid balance after 90 days from the date of service may be turned over to our collection agency for further collection. I am responsible to pay all reasonable collection agency cost.

We value our patient relationships and want to protect patients' rights. We will terminate patients from our practice after consideration for reasons including not showing for too many appointments, not complying with medical care, being hostile to ANY staff member, or not paying your bills.

X SIGNATURE______________________________________ **DATE** ____________________

========================Notice of Privacy Practices ========================

I have read and understand the Notice of Privacy Practices.

X SIGNATURE______________________________________ **DATE** ____________________

========================= Release of Medical Records =========================

I hereby authorize the following individuals to retrieve my medical history including laboratory findings. I am also aware of the medical record fees: $5.00 handling fee plus $0.75 per page and postage cost if records are to be mailed.

X SIGNATURE.______________________________________ **DATE** ____________________

Individuals and/or family members that I give permission to retrieve my medical history including laboratory findings:

Name	Date of Birth	Relationship to Patient
Name	Date of Birth	Relationship to Patient
Name	Date of Birth	Relationship to Patient
Name	Date of Birth	Relationship to Patient

INTEGRATED DERMATOLOGY GROUP, LLC

180 North 5th Street
Ponchatoula, LA 70454

190 Greenbriar Blvd., Ste 103
Covington, LA 70433

309 West Walnut St., Ste A
Amite, LA 70422

29799 South Walker Rd
Walker, LA 70785

Financial Policy

Our practice firmly believes that a good provider/patient relationship is based upon mutual respect and good communication. We are committed to providing you with the best medical care available while being mindful of costs related to your treatment. The following is our financial policy:

Payment:

1. All copayments, co-insurance, and deductibles are due at the time of service, regardless of who brings in the patient for his/her appointment. Sitters, grandparents, divorced parents, etc., must be prepared to pay at the time services are rendered. Our offices accept MasterCard, Visa, Discover, and American Express.
2. Overpayments will be refunded to the responsible party of the patient after all charges have been processed and paid by your insurance company.

Insurance:

1. Our office participates in a variety of insurance companies. It is your responsibility to:
   A) Bring your insurance card(s) to each visit and notify us of any changes.
   B) Know your copayment, co-insurance, and deductible amounts and be prepared to pay this amount at the time services are rendered.
   C) Know your insurance company benefits (office visit coverage, diagnostic testing, etc.).
   D) If you are enrolled in a managed care insurance plan (HMO), it is your responsibly to obtain or ensure a referral is issued to our office from your primary care physician prior to the time of your appointment. If no referral is on file, you will be asked to reschedule your appointment.
2. We file to secondary insurances as a courtesy. If your secondary insurance has not paid the outstanding balance within 60 days of the date claim was filed, you will automatically become responsible for the balance of any unpaid charges.

Returned checks:

The charge for a returned check is $25.00 payable by cash or credit/debit card. This will be applied to your account in addition to the insufficient funds amount. You will then be placed on a "cash or credit/debit card only" basis following any returns. If payment for an insufficient check is not made within **10** business days, your check will be turned over to the district attorney office, and you will be responsible for all court cost that may be involved.

Unpaid balances:

I understand Benson Dermatology is not responsible for collecting payment from my insurance company. If the company delays or withholds payment of my claim, I will be responsible for direct payment. I am also responsible for any or all amounts which insurance does not pay, including deductibles, co-insurance, or charges not covered. I understand any unpaid balance after 90 days from the date of service may be turned over to our collection agency for further collection. I am responsible to pay all reasonable collection agency cost.

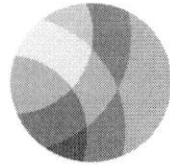
Patient Authorization

I consent to treatment, including biopsies, necessary for the care of the below named patient. I understand that I will receive a separate bill from the laboratory for each skin specimen (by law our providers are required to send skin specimens to pathologist for biopsies and surgeries).

I have read and fully understand the above consent for treatment of biopsies and Benson Dermatology's financial policy.

Patient's Name: ______________________ Date: ____________

Signature of Patient or Legal Guardian: ______________________ Date: ____________



INTEGRATED DERMATOLOGY OF PONCHATOULA, LLC
PHONE: (985) 370-7546 FAX: (985) 370-7765

180 North 5th Street
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29799 South Walker Rd
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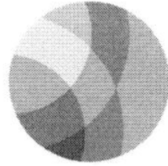
No Show Policy:

In Consideration of other Benson Dermatology patients and the staff, please give at least a 24 hour notice of an appointment cancellation. If a patients fails to show for a scheduled appointment three times without at least a 24 hour notification, the patient will be dismissed from the practice.

Patient Name: ____

Patient/Legal Guardian Signature: ____

Date: ____



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Credit Card Policy

As it has become the standard in medical practices, Benson Dermatology has implemented a credit card policy to help minimize health care costs for both our patients and office. At the time you check in, you will be asked for a credit card number and information which will be held **SECURELY** until your insurance(s) have paid their portion and notified our office of the amount you share. At that time, if your balance owed is $100.00 or less, your credit card on file will be charged. If your balance exceeds $100.00, your credit card on file will be charged $100.00, and a statement will then be mailed to you with the remaining balance owed.

This will be an advantage to you, since you will no longer have to write and mail checks to our office for balances of $100.00 or less. This policy will also be beneficial to our office, since it will decrease the number of statements generated and mailed to our patients.

I AUTHORIZE BENSON DERMATOLOGY TO CHARGE OUTSTANDING BALANCES OF $100.00 OR LESS ON MY ACCOUNT TO THE FOLLOWING CREDIT CARD:

VISA/ MASTERCARD/ DISCOVER/ AM EX (CIRCLE ONE PLEASE)

Last Four of Account Number: ____________________ Exp date: __________

CVV code: ________________________ Billing Zip code: ____________

Name On Card: ____

Signature: ___________________________ Date: _______________